EXHIBIT 961-1
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
COMMUNITY SERVICE AGENCY ~~TITLE XIX CERTIFICATION~~ APPLICATION
~~INITIAL APPLICATION~~

Please check the purpose of the application:

☐ Initial Application ☐ Renewal Application ☐ Application Amendment[1]

Provider Information

Date of Application: ____/____/____ AHCCCS Provider ID #: _____

National Provider Identification (NPI): _____

Provider Name:

Provider Phone Number: ( ) _____ - _____

Provider E-Mail Address: _____

~~P~~Provider Administrative Address (if applicable): City: State:

Street Zip: County: ~~City:~~

~~Provider Facility Address[*1]:~~ City: State:

Street Zip: County:

EXHIBIT D

Program Director:

Name: _____

Credentials: _____ Phone Number: _____

Please mark a "C" for each ~~T~~/RBHA the applicant has a contract with an ~~an~~ "I" for each ~~T~~/RBHA the applicant intends to contract with.

__ Cenpatico ~~3~~ Integrated Care __ ~~Cenpatico 4~~ ~~Health Choice Integrated Care~~

__ Health Choice Integrated Care __ ~~CPSA~~ __ ~~NARBHA~~

__ ~~Cenpatico 2~~ _ Mercy Maricopa Integrated Care

Tax ID#: _____

OR

Social Security Number: _____

Please mark an "X" next to a TRBHA, if the applicant is or will be providing services ~~through the American Indian Health Plan~~ to members receiving case management/care coordination through the TRBHA.[2]

__ Navajo Nation ~~TRBHA~~ __ Gila River ~~Tribal~~

__ White Mountain __ Pascuaqua Yaqui ~~TRBHA~~

Provider Enclosures

Enclose the following with this application: (***please check the box beside each document enclosed)***

_ Ceopy of provider incorporation documents

_ Ceopy of provider charter, if any

_ ~~c~~Copy of Occupancy Permit for provider facility address

_ ~~c~~Copy of an official current passing fire inspection

Fire inspection required every two years for renewal certification

Services Provided

[1] The documents for the initial, renewal and amended applications are identical. Propose to delete the other forms and utilize a generic form that allows CSAs to designate the purpose of the application.

[2] Clarified the CSAs are not contracting the TRBHAs, but wanted to continue to identify if a CSA was providing services through AIHP to members receiving case management through the TRBHA.

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COMMUNITY SERVICE AGENCY ~~TITLE XIX CERTIFICATION~~ APPLICATION
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Check all services below that your agency provides or intends to provide~~s for which you request Title XIX Certification~~:

__ Transportation (see the AHCCCS~~ADHS/DBHS Covered~~ Behavioral Health Services Guide for service codes)
__ Self-help/Peer Service (Individual - H0038, Group -H0038HQ)
__ Comprehensive Community Support Services (Peer Support) H2016
__ Support to Maintain Employment H2025, H2026
__ Supervised Behavioral Health Day Treatment H2012
__ Comprehensive Community Support (Supervised Day) H2015
__ Personal Care T1019 or T1020
__ Home Care Training Family S5110

~~1~~ ~~This is the service address where staff will be providing services. If staff will be providing services off-site at non-CSA facilities, please attach the list of off-site addresses (not including home addresses) where staff will be providing services.~~

* This is the service address where staff will be providing services. If staff will be providing services off-site at non-CSA facilities, please attach the list of off-site addresses (not including home addresses) where staff will be providing services.

__ ~~Psychoeducational Service H2027~~
__ Skills Training (Individual - H2014, Group - H2014HQ)
__ Psychosocial Rehabilitation H2017
__ BH Prevention/Promotion Education H0025

~~Check the following age groups for which your agency will be providing services:~~

____ 0-12 ____ 13-17 ____ 18 and older

CPR certificates for direct care staff and contractors must cover the age groups for which they will be providing services.

PROGRAM DESCRIPTION

Please describe the purpose, goals and objectives of the program, including the populations that will be served (~~i.e~~i.e., children, SMI Adults).

EXHIBIT 961-~~2~~1

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

DIRECT SERVICE STAFF MEMBER/CONTRACTOR LIST

Name of Direct Service Staff Member or Contractor	Hire Date	CPR Certification Date	First Aid Certification Date	Fingerprint Clearance Card Date (if applicable)	Self Declaration of Criminal History Date (if applicable)	Services Provided BHP, BHT OR BHPP	Services Provided Must be BHP, BHT or BHPP with one year experience in providing rehabilitation services to persons with disabilities	Services Provided Must be BHP or BHT
						__Transportation __Self Help/Peer Service __Peer Support __Supervised Behavioral Health Day Treatment __Supervised Day __Personal Care __Home Care Training Family __Skills Training Psychosocial Rehabilitation	__Support to Maintain Employment __Psychoeducational Service	__BH Prevention/ Promotion Education
						__Transportation __Self Help/Peer Service __Peer Support __Supervised Behavioral Health Day Treatment __Supervised Day __Personal Care __Home Care Training Family __Skills Training Psychosocial Rehabilitation	__Support to Maintain Employment __Psychoeducational Service	__BH Prevention/ Promotion Education
						__Transportation __Self Help/Peer Service __Peer Support __Supervised Behavioral Health Day Treatment __Supervised Day __Personal Care __Home Care Training Family __Skills Training Psychosocial Rehabilitation	__Support to Maintain Employment __Psychoeducational Service	__BH Prevention/ Promotion Education

I attest that the staff members listed above will be providing only the services indicated on this form.

_______________________________________ ____________

Signature of Program Director Date

EXHIBIT 961-~~2~~1
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
DIRECT SERVICE STAFF MEMBER/CONTRACTOR LIST

EXHIBIT 961-1
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

DIRECT SERVICE STAFF/CONTRACTOR CHECKLIST

NAME OF DIRECT SERVICE STAFF/CONTRACTOR: _____

Complete the Direct Service Staff/Contractor Checklist for each direct service staff member or contractor listed

Name of provider: _____

Location(s) where staff will be providing services (if staff member or contractor will be providing services at more than one location): _____

Attach all credible evidence/documentation to this form

☐	Credible proof of age 18 or older/age 21 or older (See Table 2 of this policy for requirements related to specific services.) Credible evidence can consist of a birth certificate, baptismal certificate, or other picture ID containing a birth date, signed and dated by the staff member or contractor such as military identification, state ID card, or valid driver's license.)
☐	Reference form
☐	Copy of current driver's license (if providing transportation services)
☐	Copy of current vehicle registration (for vehicle used to provide transportation services)
☐	Copy of current liability insurance as required by A.R.S. 28-4009 (for vehicle used to provide transportation
☐	Credible evidence of meeting the requirements of a behavioral health professional, behavioral health technician or behavioral health paraprofessional (Credible evidence can consist of a copy of the license for the behavioral health professional, copies of the license or certificate and/or education/training/experience verification for the behavioral health technician, or copies of the high school equivalency diploma (completion of GED) or high school diploma or associates degree for the behavioral health paraprofessional. Unofficial transcripts will not be considered as credible evidence).)
☐	Credible evidence of one year work experience in providing rehabilitation services to persons with disabilities, if providing Ongoing Support to Maintain Employment and/or Psychoeducational Services (Credible evidence must be specific and clear documentation, indicating location and dates of staff or contractor's experience).
☐	Copy of Fingerprint Clearance Card, if providing services to persons under the age of 18 years (If a fingerprint clearance card has not been recently obtained, the provider is strongly encouraged to contact the Department of Public Safety, Fingerprinting Division, to ensure that the card is valid. As per A.R.S. § 41-1758.05, a person who knowingly falsifies a material fact or who makes or uses a false fingerprint clearance card knowing the false fingerprint clearance card contains a false, fictitious or fraudulent statement is guilty of a class 3 misdemeanor. If a direct service staff member is continuously employed or contracted with a CSA that provides services to persons under 18 years of age, the fingerprint clearance card must be obtained every six years - Department of Public Safety: http://www.azdps.gov. Application packets for initial or renewal of fingerprint clearance cards may be obtained by calling the Department of Public Safety, Fingerprinting Division, at (602) 223-2279 or faxing the request for an
☐	Copy of DPS Form 802-06857 Applicant Fingerprint Clearance Card Application and copy of the completed and notarized State of Arizona Criminal History Affidavit form, if providing services to persons under the age of 18 years and does not have a Fingerprint Clearance Card (Application packets for initial or renewal of fingerprint clearance cards may be obtained by calling the Department of Public Safety, Fingerprinting Division, at (602) 223-2279 or faxing the request for an application to (602) 223-2947.)
☐	Copy of the completed and notarized ADHS/DBHS Self-Declaration of Criminal History form, if providing services to persons age 18 and older.

☐	Copy of current Cardiopulmonary Resuscitation (CPR) Certificate signed by the instructor (If the CPR Certificate provided indicates that it is valid for infants/children, it will be accepted for staff and contractors who are only working with persons under the age of 18. If the CPR Certificate indicates that it is valid for adults, it will be accepted for staff and contractors who are only working with persons aged 18 and older).

NAME OF DIRECT SERVICE STAFF/CONTRACTOR~~NAME OF DIRECT SERVICE STAFF/CONTRACTOR~~: _

☐ Copy of First Aid training verification signed by the instructor

~~are only working with persons aged 18 and older.)~~

☐ Credible evidence of current freedom from infectious pulmonary tuberculosis (Signed and dated letter or report from a qualified medical practitioner administering the test and reading the results. Results must clearly indicate that the qualified medical practitioner determines that the direct service staff member or contractor is medically safe to provide services. Credible documentation shall be dated at the start of employment or prior to providing behavioral health services and every 12 months thereafter.)

~~Copy of First Aid training verification signed by the instructor~~

~~Credible evidence of current freedom from infectious pulmonary tuberculosis (Signed and dated letter or report from a qualified medical practitioner administering the test and reading the results. Results must clearly indicate that the qualified medical practitioner determines that the direct service staff member or contractor is medically safe to provide services. Credible documentation shall be dated at the start of employment or prior to providing behavioral health services and every 12 months thereafter.)~~

TRAINING ATTESTATION FORM

NAME OF DIRECT SERVICE STAFF/CONTRACTOR:~~NAME OF DIRECT SERVICE STAFF/CONTRACTOR:~~ _____

Direct service staff and contractors must complete all trainings listed below prior to providing direct services to members~~behavioral health recipients~~. ~~-~~Credible evidence of training must clearly indicate to reviewers of the application that direct service staff or contractors have received training in the specified content areas (i.e., training with different titles must be matched up to the trainings listed below).

Training Content	Date of Completion	Name of Person/Organization that provided training
Client rights		
Providing services in a manner that promotes client dignity, independence, individuality, strengths, privacy and choice		
Recognizing common symptoms of and differences between a mental disorder, personality disorder, and/or substance abuse		
Protecting and maintaining confidentiality of client records and information		
Record keeping and documentation		
Ethical behavior such as staff and client boundaries and the inappropriateness of receiving gratuities from a client		
Recognizing, preventing or responding to a client who may be a danger to self or a danger to others; behave in an aggressive or destructive manner; need crisis services or be experiencing a medical emergency		

SIGNATORY INFORMATION~~Y INFORMATION~~

By signing below, I affirm under penalty of law that the information provided on this form is true, accurate, and complete to the best of my knowledge.

_____ _____

Signature of Provider Director/Title Date

By signing below, I affirm that the information provided has been reviewed for completeness and accuracy.

_____ _____

Signature of ~~T~~/RBHA Reviewer Date

COMMUNITY SERVICE AGENCY ~~TITLE XIX CERTIFICATION INITIAL~~ APPLICATION INSTRUCTIONS[3]

Initial Application Instructions: Complete all sections of the application form and enclose all required forms, certifications, permits, inspections, and documents with the application form. ~~Documents that are purchased online and are not obtained through the applicable authority will not be considered as official or credible documentation.~~

Renewal Application Instructions: Enclose a copy of the current passing fire inspection referenced in the renewal application every two years from the initial application date. Enclose a copy of the current health and safety inspection and/or copy of the Occupancy permit, if changed.

Complete sections of the renewal application for new direct service staff members or contractors hired after the previously submitted application.

Enclose all required forms, certifications, permits, inspections, and documents with the application form for new direct service staff members or contractors. Only documentation that has been updated, as required, for previous direct service staff members or contractors must be submitted (e.g., fingerprint clearance cards, CPR certification, First Aid training).

Amendment Application Instructions: Complete all sections of the application form and enclose all required forms, certifications, permits, inspections, and documents with the application form.

General Application Instructions:

The provider Director signs and dates the application form and indicates his/her title on the form.

The completed application is mailed or hand delivered to the ~~T~~/RBHA with which the provider plans to contract.

Note: Documents that are purchased online and are not obtained through the applicable authority will not be considered as official or credible documentation.

~~Community Partnership of Southern Arizona~~	~~535 N. Wilmot, Suite 201 Tucson, AZ 85711~~
~~Cenpatico Behavioral Health of Arizona~~ Cenpatico Integrated Care	333 E. Wetmore Road Tucson, AZ 85705~~1501 W Fountainhead Corporate Park Suite 295~~
~~Northern Arizona Regional Behavioral Health Authority~~ Health Choice Integrated Care	1300 S. Yale Street~~410 N. 44 Street, Ste. 900~~ Flagstaff, ~~Arizona~~ AZ 86001~~Phoenix, AZ 85008~~
Mercy Maricopa Integrated Care	4350 E. Cotton Center Blvd., Building D Phoenix, AZ 85040
~~Gila River Tribal Community~~	~~Department of Health Services Behavioral Health Care Clinic/RBHA P.O. Box 38 Sacaton, Arizona 85247~~

[3] Merged all of the instructions for each type of application into one instructional document.

The Navajo Nation	P.O. Box 2505 Window Rock, Arizona 86515
Pascua Yaqui Tribe	Pascua Yaqui Tribal RBHA 7474 South Camino DeOeste Tucson, Arizona 85757
White Mountain Apache Tribe	PO Box 1089 249 W. Ponderosa Drive Whiteriver, AZ 85941

The T/RBHA reviews the proposed provider's application for completeness, and the T/RBHA reviewer signs the application. Once it is determined that the application is complete, the T/RBHA forwards the completed application packet to:

Arizona Department of Health Services Division of Behavioral Health Services Attention: Policy Office
150 N. 18th Avenue, Suite 260
Phoenix, Arizona 85007

Arizona Health Care Cost Containment System
Division of Health Care Management
Attention: Compliance Program Specialist
701 E. Jefferson, MD 6500
Attention: Compliance Program Specialist
Phoenix, Arizona 85034